88-2055

Supreme Court, U.S.
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No.

IN THE SUPREME COURT OF THE UNITED STATES

October Term, 1988

ANTHONY M. RIZZI,
PETITIONER

v.

BLUE CROSS OF SOUTHERN CALIFORNIA,
RESPONDENT

PETITION FOR A WRIT OF CERTIORARI TO THE COURT OF APPEALS, FOURTH APPELLATE DISTRICT, DIVISION ONE OF THE STATE OF CALIFORNIA

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QUESTIONS PRESENTED FOR REVIEW

1. Whether or not suits alleging improper claims processing under group health insurance policies are governed solely by federal law under ERISA even when California law relating to claims expressly regulates insurance.

2. Where a group health insurance policy was not ever expressly referred to as an ERISA plan, what criteria are to be used to classify it as an ERISA plan?

3. Whether all group health care insurance policies sold in California by health insurance companies are employee benefit plans under the Employee Retirement Income Security Act (ERISA) because employers pay all or part of the premiums to an insurance company but are not otherwise involved in administration or

claims and the policy is not expressly designated an ERISA plan.

4. Whether or not there exists any non-ERISA employer group health insurance in California; and, if so, what criteria will determine whether such a plan exists.

5. Whether or not the criteria of identifying an ERISA plan should include 1) the intent of the parties in negotiating the contract at the time 2) language of the contract and 3) full and adequate disclosure to the employer and to the employee that the insurer intends the plan to be one covered by ERISA.

6. Whether or not the action of the California Supreme Court and the California Court of Appeals deprived Petitioner of a property interest in his

causes of action in violation of the Fourteenth and Fifth Amendments of the United States Constitution.

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OPINIONS BELOW

The Petition seeks review of a judgment of the Supreme Court of California filed February 23, 1989 denying review of a decision of the Court of Appeal, Fourth Appellate District, Division One filed December 2, 1988.

The opinion of the California Supreme Court is appended hereto at 1a.

The opinion of the California Court of Appeal is appended hereto at 1b and is reported at 206 Cal. App 3d 380, 253 Cal Rptr. 541 (1988).

JURISDICTIONAL STATEMENT

Jurisdiction is invoked pursuant to 28 U.S.C. Section 1257(a). The filing date of the judgment of the California Supreme Court was February 23, 1989.

STATUTES INVOLVED

Provisions involved are lengthy.

Pertinent text of the following statutes are set forth in appendix 1c §3(1), (7) and (8), 29 U.S.C. Sections 1002 (1), (7) and (8), 29 U.S.C. Section 502(a), 29 U.S.C. §1121(a); §505, 29 U.S.C. §1135; §514(a), 29 U.S.C. §1144; 29 C.F.R. §2510.3-1(j) (1987) 29 C.F.R. §2560.503.1(g) (2) (1987).

STATEMENT OF THE CASE

A. Stage of Proceedings:

Blue Cross of Southern California[1] moved for summary judgment in a Superior Court in San Diego, California, on the grounds that ERISA preempted the action. The Superior Court granted the motion and Petitioner (Mr. Rizzi) appealed. A California Court of Appeals affirmed the trial court and the California Supreme

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1 Blue Cross of Southern California is the only party to the proceeding in the Court whose judgment is sought to be reviewed.

Court denied review.

B. Facts Pertaining to Questions Presented

Mr. Rizzi's employer, New Way Enterprises was a small publishing business. Like many small businesses in California, the employer was solicited by a group health insurer offering group plans from minimum group sizes of three and sometimes two.

Like the smallest group plans, the employer completed a census and was given a rate by the insurer. The employer mailed premium checks to the insurer, Blue Cross, beginning sometime in 1975, but had no other involvement in the policy. The policy was not negotiated or sold as an ERISA plan.

C. Facts Pertaining to the Merits

In 1975 Mr. RIZZI became ill. On or before February 1, 1977 Petitioner RIZZI'S employer sent a notice to BLUE CROSS requesting cancellation of the group insurance policy. Mr. RIZZI was not aware of this action by his employer. BLUE CROSS had not informed Mr. RIZZI of this action. BLUE CROSS cancelled the contract, but not due to the employer's action. The reason given by BLUE CROSS records was that Mr. RIZZI had open heart surgery and that he was a frequent emergency room visitor.

BLUE CROSS then destroyed the notification from the employer. About two weeks afterward, BLUE CROSS filed a lien in Mr. RIZZI'S Workers' Compensation action. As of that date, BLUE CROSS did not inform Mr. RIZZI of the pending termination of the policy, even

though it could have through the Workers' Compensation correspondence.

Not only was Mr. RIZZI unaware of the termination date of his policy, he was also unaware of the termination date of his employment. Thus, the controlling date under the certificate was the date Mr. RIZZI'S employer paid the last monthly subscription on his behalf.

From February 1, 1977 onward, Mr. RIZZI'S policy was in jeopardy due to the employer's non-payment of premiums. This non-payment is indicated on a remittance sent by the employer, and automatically informs the group insurer that a member is cancelled. The employer paid a final premium for Mr. RIZZI at the time it requested cancellation of his policy. BLUE CROSS was intimately aware of the date of the

date the employer paid the last monthly subscription payment. Mr. RIZZI had no way of learning this date or the number of days that he was insured after the final payment. This date was crucial because BLUE CROSS contends that Mr. RIZZI had fifteen days from the termination date of the policy to exercise an option to convert the policy. BLUE CROSS was not, and is not, concerned how an employee discovers the termination date from information exclusively in the insurers' control. Its position is that it has no duty to notify an insured of his or her conversion option.

Mr. RIZZI contends that BLUE CROSS had an absolute duty to notify him of the termination date. Had he received this vital notice, he would have pursued his conversion rights.

BLUE CROSS would then have had to permit Mr.RIZZI to exercise his conversion option.

Even if BLUE CROSS had no obligation to notify insureds of their conversion rights, it waived this contractual provision by notifying insureds anyway. BLUE CROSS admits that in 1977 it notified insureds of their conversion rights. The number of notices for that year was about 120,000.

In Mr. RIZZI'S case, BLUE CROSS contends that it mailed this notice re conversion rights on March 10, 1977. Appen. 39. Mr. RIZZI denies that the notice was sent. BLUE CROSS never explained why it waited over forty days from termination of the policy to send a notice to Mr. RIZZI regarding conversion.

D. The Actions Held Preempted By ERISA

There are six causes of action:

1. Breach of Duty of Good Faith and Fair Dealing.

2. Breach of Fiduciary Duties.

3. Fraud.

4. Breach of Statutory Duties.

5. Declaratory relief.

6. Common Count.

The facts alleged are as follows. Facts unique to a particular cause of action will be set forth in the appropriate paragraph:

First Cause of Action:

On or about January, 1975, plaintiff became covered under a group health insurance policy; Mr. RIZZI performed all obligations under said policy. He became seriously ill on or about August

11, 1975 and filed claims for benefits. Defendant BLUE CROSS refused to pay benefits. It delayed and withheld benefits knowing the same were due. BLUE CROSS misrepresented policy provisions and failed to investigate and process claims. BLUE CROSS didn't attempt to settle the claims in good faith or to reasonably explain the denial of claims. This conduct damaged the plaintiff.

Second Cause of Action:

In addition to the foregoing, defendant refused to pay a sum of money which was thereafter held, in trust, for plaintiff. Appen. 80.

Third Cause of Action:

In addition to the foregoing, BLUE CROSS promised to insure plaintiff with-

out intending to perform the promises.

Fourth Cause of Action

In addition to the foregoing, BLUE CROSS violated section 790.03 of the California Insurance Code.

Fifth Cause of Action

A controversy has arisen with respect to the foregoing.

Sixth Cause of Action

By reason of the foregoing, Defendant BLUE CROSS is indebted to Mr. RIZZI.

REASONS THE WRIT SHOULD BE GRANTED

I. THE ISSUE OF WHETHER ERISA PREEMPTS STATE LAW REMEDIES PROVIDED BY CALIFORNIA LAW REGULATING INSURANCE IS AN ISSUE OF WIDESPREAD

IMPORTANCE; IT IS URGENT THAT THIS COURT RESOLVE THIS ISSUE.

The first question presented comes within the criteria of Supreme Court Rule 17.1. It is of tremendous importance and impacts on the rights of small businesses who buy group insurance in group sizes beginning at two or three in California as well as millions of citizens of this country who have garden variety employee group health and medical insurance policies and seek State law remedies when the insurers' failure to honor these policies causes serious hardship to ill and disabled policyholders. Further, this question impacts Federal Courts generally, who may be called upon to decide many ERISA claims in the future. This issue was also presented to this court in the petitions

for writ of certiorari in Commercial Life Insurance Co. v. Superior Court (Juliano) 47 Cal. 3d 473, 764 P.2d 1059 (1988) and Kanne v. Connecticut General Life Insurance Co. 859 F 2d 96 (9th Cir. 1988).

Indeed, the importance of this issue has been conceded by one of Connecticut General's counsel, David L. Bacon, Esq., who has said that "[i]t's hard to overstate the importance" of the Court of Appeals' decision in the instant case (Los Angeles Daily Journal, October 5, 1988, p.1., column 4) and "[t]here are hundreds of pending suits in California which involve this very issue and hundreds and [sic] millions of dollars [are] involved." (Wall Street Journal, October 5, 1988, p.A-24, column 4).

In California alone, there are

scores, if not hundreds, of cases pending whose resolution is determined by the issue of whether a citizen of a State may seek State law remedies for redress of violations of State laws regulating insurance. If review is not granted in the case at Bench, claims disputes under the smallest group insurance policies for "mom and pop" businesses in California (many times operated at home), will be confined to the federal ERISA remedies. Further, insurance companies will not be required to disclose that a group sale involves ERISA'S exclusive claims remedies and that the plan involves enormous burdens for small employers. In many small businesses, the employers would now be better off purchasing individual plans at higher rates rather than purchasing ERISA plans.

In Commerical Life Ins. Co. v. Superior Court, supra, the California Supreme Court, in holding that actions for breach of State laws regulating insurance are preempted by ERISA, relied extensively on the decision of the Court of Appeals in the Kanne case. See 47 Cal. 3d at pp. 482-484, 764 P.2d at pp. 1064-1066.

Although the California Supreme Court has now judicially abolished the private right of action under California Insurance Code Section 790.03(h), the Court made it clear that the Legislature of the State of California has the power to reinstate this right of action. Moradi-Shalal v. Fireman's Fund Ins. Cos. 46 Cal.3d 287, 305, 758 P.2d 58, 69 (1988). Moreover, the Moradi-Shalal decision applies prospectively only, and

does not affect the present case as well pending cases asserting causes of action under California Insurance Code Section 790.03(h). See 46 Cal.3d at p.305, 758 P.2d at p. 69. Further, the RIZZI decision also means that there is no longer a state antitrust cause of action based upon claims practices in California against group health insurers due to federal preemption. See Cal. Ins. Code §790.03(c). In the group health field, insurers in California are now free of both Federal and State antitrust regulation in the area of claims.

Nor is the reach of the present issue confined to California. Numerous other states have laws which seek to deter unfair insurance practices by assessing various penalties. See, e.g.: Van Dyke v. St. Paul Fire & Marine Ins. Co., 448 N.E.2d 357 (Mass. 1983) (cause of action

allowed for breach of Massachusetts' Insurance Unfair Claims Practices Act); Griswold v. Union Labor Life Ins. Co., 442 Atl.2d 920 (Conn. 1982) and Mead v. Burns, 509 Atl.2d 11 (Conn. 1986) (cause of action allowed for breach of Connecticut's Unfair Trade Practices Act); Sparks v. Republic Nat. Life Ins. Co., 647 P.2d 1127 (Ariz. 1982), cert. den., 459 U.S. 1070, 103 S.Ct. 490 (1982) (to the same effect under Ariz. Rev. Stats §20-443); Jenkins v. J.C. Penney Cas. Ins. Co., 280 S.E. 2d 252 (W.Va. 1981) (to the same effect under West Virginia statute); Klaudt v. Flink, 658 P.2d 2065 (Mont. 2983) (to the same effect under Montana statute); Mo. Rev. Stat. §375.296 (allowing extra-contractual damages and attorneys fees against insurance companies for vexatious refusal to pay); Tex. Ins.

Code Ann. Art. 3.62 (same); La. Rev. Stats 22:657 (providing for penalties for failure to promptly pay claims arising out of health and accident contracts).

The foregoing statutes, and similar statutes in other states, will be rendered a nullity under the California Appellate Court's decision at Bench and the Kanne Court's interpretation of this Court's decision in Pilot Life, 481 U.S.41 particularly as to the preemption allowed by both courts. The Kanne Court's interpretation of Pilot Life and California's interpretation at Bench in effect attribute to this Court's opinion in Pilot Life a statutory interpretation which ignores the plain words of the statute. The Kanne Court's interpretation is that the savings clause does not apply to

ERISA's enforcement provisions. This is incorrect.

The savings clause provides that "nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance..." 29 U.S.C. Section 1144(b)(2)(A) (emphasis added). The "subchapter" referred to is Subchapter I of ERISA, entitled "Protection of Employee Benefit Rights." The savings clause is in Part 5 of Subchapter I. The ERISA enforcement provisions are also in Part 5 of Subchapter I. See 29 U.S.C. Section 1132. Hence, the statute clearly provides that ERISA's enforcement provisions do not apply to State laws regulating insurance. To interpret Pilot Life as holding otherwise would impute to this Court an intention to ignore the plain words of the

statute--an intention which cannot be imputed to this Court.

It is particularly inappropriate to impute such an intention to this Court from statements in the Pilot Life decision because the issue was not before this Court in Pilot Life. Pilot Life did not involve a State law regulating insurance. Two other Court of Appeals decisions have interpreted Pilot Life in a fashion similar to the Ninth Circuit's interpretation. See, e.g.: In Re: Life Ins. Co. of North America, 857 F.2d 2290 (8th Cir. 1988) (the Court held that ERISA preempts Mo. Rev. Stat. Section 375.420, which provides a penalty for vexatious refusal to pay insurance benefits. The Court relied on the second portion of the Pilot Life opinion, which it construed as holding that "no

state law purporting to supply additional remedies will escape the preemptive effect of Section 1144(a) as laws 'which regulate insurance' under Section 1144 (b)(2)(A)" [857 Fed. 2d at p.1194]); Anschultz v. Connecticut General Life Ins. Co., 850 F.2d 1467 (11th Cir. 1988) (holding that under Pilot Life, ERISA preempts the Florida Insurance Unfair Practices Act, Florida Stat. Section 624.155. The Court, relying on the second portion of Pilot Life, held: "where otherwise applicable, ERISA preempts all state law." [850 F.2d at p.1469] [emphasis in original]).

The more rational interpretation of the second half of Pilot Life--and the interpretation consistent with the statutory language--is that the discussion therein was intended to set out

another element to consider in determining whether a State law regulates insurance so as to come within the saving clause. In discussing the criteria to be utilized in determining whether the saving clause applies, this Court in Pilot Life said that several considerations guided it. 481 U.S. at p.48, 107 S.Ct. at p. 1553. First, this Court was guided by a "common-sense view of the language of the saving clause itself" (ibid). Then, it applied the three criteria set forth in Union Labor Life Ins. Co. v. Pierno, 458 U.S. 119, 129, 102 S.Ct. 3002, 3009 (1982) (481 U.S. at pp. 48-51, 107 S.Ct. at pp. 1553-4). Finally, in the portion of Pilot Life relied on by the Court of Appeals in the instant case, this Court considered the role of ERISA in promoting uniformity of

enforcement for actions by ERISA-plan participants and beneficiaries (481 U.S. at pp. 51-57, 107 S.Ct. at pp.1555-1558).

This last criterion constitutes a criterion this Court considered in determining the scope of the saving clause and it alone cannot take a state law regulating insurance outside the ambit of the saving clause. Otherwise, it would, as occured at Bench, nullify the saving clause completely, and would make superfluous this Court's previous discussion in the Pilot Life opinion as to whether the State law in question regulated insurance and satisfied the Union Labor Life requirements.

Thus, the opinion in Pilot Life concludes with the statement that the "state law suit asserting improper processing of a claim for benefits under

an ERISA-regulated plan is not saved by Section 514(b)(2)(a) and therefore is pre-empted by Section 514(a)." (481 U.S. at p. 57, 107 S.Ct. at p.1558) (emphasis added). This means that the suit was pre-empted because the law involved was not a State law regulating insurance within the saving clause. It does not mean that suits, as here, based on State laws which do regulate insurance and are hence within the saving clause are also subject to pre-emption. If this Court intended to hold that ERISA's enforcement provisions preempt all State laws regardless of whether or not they regulate insurance, it would have been wholly unnecessary for this Court to extensively disucss all of the reasons that the Mississippi common law rules involved in Pilot Life did not constitute

a state law regulating insurance.

This conclusion is supported by this Court's decision in Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 105 S.Ct. 2380 (1985), where this Court held that there is a presumption against pre-emption of areas of "traditional state regulation" (471 U.S. at p.740, 105 S.Ct. at p.2389) and that "we are not inclined to read limitations into federal statutes in order to enlarge their pre-emptive scope." (471 U.S. at p.741, 105 S.Ct. at p.2390). This Court rejected the contention that "Congress intended [a] narrow reading of the saving clause." (471 U.S. at pp. 745-746, 105 S.Ct. at p. 2392. See also 471 U.S. at pp. 746-747, 105 S.Ct. at p.2393). This Court stated that the saving clause is "broad on its face" (471 U.S. at p.746, FN 24, 105

S.Ct. at p.2393, FN 24). These statements establish that the saving clause may not be nullified by refusing to apply it to a situation that comes squarely within its terms.

The interpretation of the California Court of Appeals in the instant case would mean that this Court did a complete about face only two years after Metropolitan life was decided. Pilot Life contains nothing to indicate that this Court intended to effect such a sweeping reversal of the holding in Metropolitan Life.

It is submitted that the District Court in Graves v. Blue Cross of California, 688 F.Supp. 1405 (N.D. Cal. 1988) correctly interpreted Pilot Life. The Court there rejected the interpretation that the second half of Pilot Life

limited actions under State laws regulating insurance to ERISA remedies, saying:

> "...such a holding would conflict with both the language of ERISA itself and the Supreme Court's pronouncements in Metropolitan Life. . .Since ERISA's civil enforcement provisions are contained in the same subchapter as the saving clause, see 29 U.S.C. Section 1132, the plain language of the statute precludes a ruling that state laws falling within the boundaries of the saving clause are nevertheless preempted if they interfere with the policies underlying the exclusive civil enforcement scheme. In effect, such a holding would rewrite the saving clause..." (688 F. Supp. at pp. 1412-1413) (emphasis added).

The District Court then noted the language of Metropolitan Ins. Co. v. Massachusetts, supra, and said:

> "In this Court's view, the only way to square Pilot Life with Metropolitan Life and the plain language of ERISA is to read the Pilot

Life exclusivity analysis as merely bolstering the Court's apparent conclusion that the Mississippi bad faith law was not insurance regulation within the meaning of the saving clause. In other words, the insurance regulation and exclusive remedy discussion in Pilot Life are not independent, alternative holdings, but interdependent considerations supporting the Court's conclusion that the saving clause does not apply." (688 F.Supp. at p.1413) (emphasis added).

In Commerical Life, supra, the dissenting opinion of Justice Mosk (joined in by Justice Broussard) points out that under the statute it is plain

> "that Section 790.03(h) is saved from preemption by the express terms of ERISA: the provision clearly 'regulates insurance' [citation]. As I read their opinion, the majority do not seriously dispute that section 790.03(h) comes within ERISA's saving clause--nor could they [citation]. * * * ERISA does not preempt Section 790.03(h), but expressly saves the provision as

a law 'regulat[ing] insurance.' Further, the civil enforcement scheme of the federal statute does not displace the civil enforcement scheme of the state act: the former concerns the rights of employees under covered plans, the latter the duties of insurers under state laws." (47 Cal. 3d at pp. 488-489, 764 P.2d at pp. 1068-1069).

Justice Mosk then said:

"There is a growing and ominous trend toward federal preemption of issues that belong within the sphere of control by the individual states. And these inroads into traditional federalism are taking place despite their inconsistency with pious rhetoric emanating from Washington about returning government to the people at state and local levels." (47 Cal. 3d at p. 490, 764 P.2d at p.1069) (emphasis added).

These comments are particularly appropriate in light of the fact that the insurance industry--with all the vast and able legal resources at its command--has been unable to cite in

support of its position one single expression from Congress in all of the writings on ERISA's legislative history. Nothing in that history shows that Congress intended to place all sick and disabled beneficiaries of small business group insurance plans at the mercy of ERISA's lack of effective remedies. To the contrary, the saving clause constitutes a plain expression of Congress' intent to leave to the States the traditional State law regulation of the duties of insurers to the States' citizens, as Justice Mosk pointed out. See also: Petition for Writ of Certiorari in Commerical Life, supra, which sets forth other authorities regarding the intent of Congress.

These serious questions concerning interpretation of Pilot Life urgently

require this Court to grant the instant petition and definitively resolve the question of whether or not the States are powerless to enact or enforce legislation designed to deter insurance companies from inflicting on a State's citizens anguish and hardship such as that suffered by Mr. Rizzi now at Bench. This issue is a vitally important question of federal law which has not been, but should be, settled by this Court (Rule 17.1(c)), regardless of whether Mr. Rizzi's right or wrong with respect to the ultimate result.

II. THE ISSUE OF THE ELEMENTS NECESSARY TO ESTABLISH THAT AN INSURANCE ARRANGEMENT IS AN "EMPLOYEE BENEFIT PLAN" SUBJECT TO ERISA IS AN ISSUE OF WIDE-SPREAD IMPORTANCE WHICH HAS

NEVER BEEN RULED ON BY THIS COURT.

The issue of the elements necessary to establish that a group insurance policy is an "employee benefit plan" subject to ERISA, pursuant to 29 U.S.C. Section 1003(a), is also appropriate for review, under the criteria of both Rule 17.1(a) and (c). As will be seen below, the instant decision is in conflict with Federal Court of Appeals decisions on this issue. It is a vital issue which affects even the smallest health insurance arrangement made in an employment setting. It affects the rights of citizens of States to pursue State law remedies in cases where an employer arranges for an insurance policy covering its employees, but there is no written employee benefit plan and

no evidence that the employer had any intention whatever to establish an employee benefit plan subject to ERISA or made any attempt to comply with the various ERISA regulations governing such plans. Such regulations include numerous onerous reporting and record keeping requirements. See, e.g. 29 U.S.C. Sections 1021-1029. An employer who willfully violates any of these provisions is guilty of a criminal act, subjecting that employer to fine and imprisonment. 29 U.S.C. Section 1131. See Taggart Corp. v. Life & Health Benefits Admin., 617 F.2d 1208, 1211 (5th Cir. 1980), cert. den. sub. nom., Taggart Corp. v. Efros, 450 U.S. 1030, 101 S.Ct. 1739 (1981).

Employers, who are subject to criminal prosecution, and employees, who are

threatened with loss of valuable rights under State law, should be clearly and definitively advised by this Court of the circumstances when an insurance arrangement constitutes an "employee benefit plan" subject to ERISA. At a bare minimum the insurer, unlike Blue Cross in the case at Bench, should clearly disclose in the policy form that the plan is an ERISA plan. Given full disclosure, no small business employer or employee would buy such a plan. The small employer would reject the burden of ERISA and the employee would reject the stripped down remedies of ERISA. If group health insurance is made mandatory by Congress this term, as proposed by Senator Kennedy, many small businesses will be forced by ERISA's burdens into noncompliance with ERISA or to go out

out of business.

This Court has never spoken on this issue. A leading case from this Court makes it clear that the provisions of ERISA do not apply unless there is a plan or program. Fort Halifax Packing Co. v. Coyne, ____ U.S. ____, 107 S.Ct. 2211 (1987). It does not address the issue of the elements necessary to establish such a plan or program or whether, as in California a non ERISA plan cannot now be purchased in the employment context.

The Kanne decision graphically demonstrates the confusion and conflict among the Courts on this issue. The Court of Appeals' finding that an unwritten "employee benefit plan" subject to ERISA existed in the present case was based on at least two propositions that are the subject of conflict among

the authorities:

(1) The proposition that the nonexistence of absence of any of the four criteria set forth in Department of Labor regulation 29 CFR Section 2510.3-1(j) is sufficient to subject an insurance arrangement to ERISA (see Appendix C.6).

The questionable nature of the first proposition is established by holdings that the nonexistence of one of the four criteria set forth in the Department of Labor regulation does not establish that an insurance arrangement is subject to ERISA. Thus, for example, in the case at Bench the California Court of Appeals analyzed the authorities and pointed out that some authorities have held that there is no ERISA plan

> "where the employer 'endorsed' the policy sold by an insurance trust, but the employer had no control of

> the trust operation, contributed no funds on behalf of the employees, and the insurance brokers sold the policies directly to individual employees who paid the entire premiums. [citations]" 206 Cal. App. 3d at p.386, 253 Cal. Rptr. at p.545 (emphasis added). (See 1.b, Appendix).

See also: Sayble v. Blue Cross of So. Cal., ___ Cal. App. 3d ___, ___ Cal. Rptr. ___, filed March 20, 1989 (reported in the Los Angeles Daily Journal Daily Appellate Reports for March 22, 1989 at p. 3587) (the Court held that payment of premiums, which established the non-existence of the first criterion in the Department of Labor regulation, was not sufficient to establish an employee benefit plan where there was no evidence of any other employer involvement).

Moreover, in the Kanne case the Court of Appeals did not even find that

Mr. Kanne's direct employer's involvement established the absence of any of the four Department of Labor criteria. The Court of Appeals found only that the acts of ABC, an alleged employer group, constituted "endorsement," establishing the absence of the third criterion.

Another conflict among the authorities is presented by the question of whether employer intent is necessary to establish an unwritten employee benefit plan subject to ERISA.

In Wayne Chemical v. Columbus Agency Service Corp., 567 F.2d 692 (7th Cir. 1977), the Court held that an employee benefit plan governed by ERISA is not established when the employer applies for insurance and pays premiums "without any knowledge that the plan exists. Establishing, maintaining or participating

in a plan requires an intent, ..." (567 F.2d at p.699) (emphasis added). Similarly, the opinion of the Court of Appeals in Kanne also indicates that an intent to form an ERISA plan is necessary, since it found such intent, although only on the part of ABC.

On the other hand, Donovan v. Dillingham, supra, indicates that intent is unnecessary, since it sets forth different criteria for determining whether a plan is governed by ERISA (688 F.2d at p. 1373).[16] This case, specifically raises the question of "whether a test based on an employer's subjective intent is appropriate." 206 Cal. App. 3d at p.387, FN 7, 253 Cal. Rptr. at p.545, FN 7, Appendix 1.b, pg.17.

Federal Courts of Appeal are also in conflict on the subject of whether the

"bare purchases of health insurance" may constitute a "plan" subject to ERISA.

The Donovan test is "whether from the surrounding circumstances a reasonable person could ascertain the intended benefits, beneficiaries, source of financing, and procedures for receiving benefits" (688 F.2d at p. 1373).

Taggart Corp. v. Life & Health Benefits Admin., supra, 617 F.2d 1208, 1211, held that there is no ERISA plan under these circumstances. Donovan v. Dillingham, supra, holds that "bare purchases of health insurance" is evidence of an employee benefit plan governed by ERISA and the issue is one of fact to be decided on a case by case basis (688 F.2d at p.1373). Donovan specifically disapproves the holding of Taggart Corp., supra, on this subject. (688

F.2d at p. 1375).

In this case, the California Court of Appeal noted the confusion and inconsistency among the authorities (206 Cal. App. 3d at pp. 384-388, 253 Cal. Rptr. at pp. 543-546), stating that the various "analytical approaches" the Courts have considered "do not always coincide" (206 Cal. App. 3d at p. 389, 253 Cal. Rptr. at p. 547), Appendix 1b.

Indeed, as noted above, other counsel have advised this Court that there is "An Increasingly Significant Circuit Split And Wide-Spread Division And Error In The Lower Courts" on this subject (Petition in Pacific Mutual Life Ins. Co. v. Turnbow, supra, p. 16); a "sharp Circuit conflict" on this subject (id. at p. 18); and "increasing division and error in the lower courts

on ERISA's most basic issues of coverage and preemption, all stemming from an irreconcilable Circuit conflict." (id. at p. 19).

Unmentioned in these disputes are whether, as here, the bare purchase of group health insurance by an employer should require disclosure by the insurance carrier to both the employee and employer that the policy is an ERISA plan. Given full disclosure, most small businesses would simply purchase individual plans and avoid ERISA altogether.

The certainty so urgently needed on this subject is lacking, and it is vital that this Court issue a clear pronouncement of understandable criteria that determine what constitutes an employee benefit plan governed by ERISA,

under 29 U.S.C. Section 1003(a).

Otherwise, vague, ambiguous and obscure criteria determine this question. Further, clarity is needed because of the criminal sanctions which may be imposed upon unwary small businesses for failure to comply with ERISA requirements, under 29 U.S.C. Section 1131. It is elementary that a criminal statute must be plain and unambiguous. Under current authorities, as well as in the group policy sold to Mr. Rizzi's employer, there is no way of knowing with certainty when ERISA is applicable and when the duty of compliance with ERISA regulations arises.

It is now necessary that the state and federal courts throughout this country receive concrete guidance from this Court on this subject. Otherwise, confusion and uncertainty will prolif-

erate and will create intolerable chaos in the state and federal court systems, to the detriment of thousands of small businesses and group insureds.

Conclusion

This Court's decision in Pilot Life, supra, urgently requires clarification in order that the States may know whether or not they have the power to enact laws regulating insurance which will effectively deter predatory insurance practices such as those demonstrated by the record at Bench. It was never the intention of Congress to handcuff the States' ability to protect citizens within their borders from the hardships which may result from such practices. Nor did Congress intend to confine all remedies in employer group health,

regardless of size, to ERISA.

It is also urgently necessary that the State and Federal Courts be afforded guidance with respect to when the federal law embodied in ERISA applies to medical and disability insurance arrangements that are not the subject of any written employee benefit plan. The consequences of the present state of confusion and uncertainty are most grave. All sides to this controversy agree that an authoritative pronouncement from this Court is necessary to prevent the further spread of this deeply troubling confusion and uncertainty.

Date: May 2, 1989

Respectfully submitted,

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APPENDIX

Filing date:
February 23, 1989

APPENDIX

ORDER DENYING REVIEW

AFTER JUDGMENT BY THE COURT OF APPEAL

4th District, Division 1, No. D006848
S008573

IN THE SUPREME COURT OF THE
STATE OF CALIFORNIA

I N B A N K

ANTHONY M. RIZZI, Appellant

v.

BLUE CROSS OF SOUTHERN CALIFORNIA, ET AL.
Respondents

Appellant's petition for review DENIED

Mosk, J. and Kaufman, J., are of the opinion the petition should be granted.

1b Filing date:
December 2, 1988

CERTIFIED FOR PUBLICATION

COURT OF APPEAL,
FOURTH APPELLATE DISTRICT

DIVISION ONE

STATE OF CALIFORNIA

ANTHONY M. RIZZI,	)	
	)	
Plaintiff and Appellant,	)	
	)	
v.	)	D006848
	)	
BLUE CROSS OF SOUTHERN CALIFORNIA, et al.,	)	
	)	
Defendants and Respondents.	)	Sup. Ct, No. 463834
	)	

APPEAL from a judgment of the Superior Court of San Diego County, Richard Huffman, Judge. Affirmed.

Stephen M. Shaw and Nicholas De Pento for Appellant.

Gary, Cary, Ames & Frye, William S. Boggs, Charles L. Dee, Munger, Tolles & Olson and Daniel P. Garcia for

Respondent.

Anthony Rizzi appeals a summary judgment against Blue Cross of Southern California (Blue Cross) after the trial court concluded Rizzi's complaint -- alleging, inter alia, violations of California Insurance Code section 790.03 in the denial of his claim for medical benefits under his employer's group insurance policy -- was preempted by the Employee Retirement Income Security Act (ERISA; see 29 U.S.C. [1] section 1001 et seq.). We affirm the judgment because we conclude substantial evidence supports the trial court's finding the group insurance program was an employee welfare benefit plan established by Rizzi's employer under ERISA and the cause of action based on California Insurance Code

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1 All statutory references are to Title 29 of the United States Code, unless otherwise specified.

section 790.03 is preempted by ERISA (section 1144).

I

Rizzi's complaint alleges that in January 1975, Blue Cross issued an employees group health insurance policy to his employer, New Way Enterprises. After being notified by Blue Cross that he was insured, he incurred medical expenses, for which he filed a claim. However, Blue Cross allegedly failed and delayed to make medical benefit payments knowing he was entitled to them and with insufficient information to justify their action, misrepresented policy provisions, failed to promptly investigate and process his claims, did not attempt to settle his claims when liability was reasonably clear, and failed to provide a reasonable explanation for denying his claim. The complaint alleges Rizzi paid premiums for the insurance coverage.

II

EXISTENCE OF AN ERISA PLAN

Rizzi argues there was an insufficient showing his Blue Cross insurance is an employee welfare benefit plan subject to ERISA.

Statutory definitions

ERISA protects "...participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts." (section 1001, subd. (b); Pilot Life Ins. Co. v. Dedeaux (1987) 107 S.Ct. 1549, 1551.)

ERISA defines an "employee welfare

benefit plan" as including "any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits ..." (section 1002, subd. (1).) ERISA applies to "any employee benefit plan if it is established or maintained -- (1) by any employer engaged in commerce or in any industry or activity affecting commerce ..." (section 1003, subd. (a).)[2]

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2 On appeal, Rizzi does not contend New Way was not engaged in interstate commerce or an industry affecting commerce. (See section 1002, subd. (11).)

The Department of Labor identifies group insurance programs offered by an insurer to employees which are not under ERISA, stating:

> "...the terms 'employee welfare benefit plan' and 'welfare plan' shall not include a group-type insurance program offered by an isurer to employees or members of an employee organization, under which
>
> "(1) No contributions are made by an employer or employee organization;
>
> "(2) Participation [in] the program is completely voluntary for employees or members;
>
> "(3) The sole functions of the employer or employee organization with respect to the program, to permit the insurer to publicize the program to employees or members, to collect premiums through payroll deductions or dues checkoffs and to remit them to the insurer; and
>
> "(4) The employer or employee organization receives no consideration in the form of cash or otherwise in connection with the program, other than reasonable compensation, excluding any profit, for administrative services actually rendered in connection with payroll deductions or dues

Case precedent

The issue is whether New Way "established or maintained" an "employee benefit plan" as required by sections 1002 and 1003.

Courts readily find the existence of an ERISA plan where an employer pays the premiums for its employes' insurance coverage and significantly administers the insurance program (i.e. processes claims). (See, e.g., opinion of this court in Drummond v. McDonald Corp. (1985) 167 Cal.App.3d 428, 432.) As we discuss below, the evidence presented here does not show New Way processess claims or otherwise significantly administers the insurance policy. Thus, we examine federal precedent addressing what constitutes an ERISA plan in more borderline cases. These decisions state

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checkoffs."
(29 C.F.R. section 2510.3-1(j).)

the existence of an ERISA plan is a question of fact to be resolved in light of all surrounding facts and circumstances from the point of view of a reasonable person. (Donovan v. Dillingham (11th Cir. 1982) 688 F.2d 1367, 1373; Credit Managers Ass'n v. Kennesaw Life & Acc. Ins. (9th Cir. 1987) 809 F.2d 617, 625; Kanne v. Connecticut General Life Ins. Co. (9th Cir. 1988) 859 3 F.2d 96, 98.)

Federal decisions use the Department of Labor regulation (29 C.F.R. section 2510.3-1(j)), quoted above, as an analytic springboard. To summarize, the regulation indicates ERISA plans do not include those under

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3 Some federal cases discussed herein arise in the context of a suit brought alleging violations of duties under ERISA, whereas others arise in the context of federal preemption of a state action.

which the employeer makes no contributions; participation is completely voluntary; the employer plays a limited role (i.e. does not endorse the plan, but only collects and remits premiums, and allows the insurer to publicize); and the employer receives no considerations other than compensation for administrative services.

Some federal cases indicate an ERISA plan may exist where the employer contributes toward the premiums, even when not otherwise significantly administering the program. (Donovan v. Dillingham, supra, 688 F.2d at pp. 1372-1375 [employer purchased group insurance either pursuant to collective bargaining agreement or continuing practice of purchasing insurance for class of employees]; Local Union 2134, UMW of America v. Powhatan Fuel (N.D.Ala. 1986) 640 F.Supp. 731, 734-735, vacated on

other grounds in Local Union 2134, UMW of America v. Powhatan Fuel (11th Cir. 1987) 828 F.2d 710; see dicta in Credit Managers Ass'n v. Kennesaw Life & Acc. Ins., supra, 809 F.2d at p. 625 ["Even if an employer does no more than arrange for a 'group-type insurance program,' it can establish an ERISA plan, unless it is a mere advertiser who makes no contributions on behalf of its employees."].)

In contrast, no ERISA plan was found where the employer made no contributions to the premiums, but entered into a "group unit purchase contract" with an insurance company, under which the employer permitted the insurance company to offer its annuity plans to the employees, and if the employee chose a plan, he directed the employer to contribute a portion of his salary to purchase the annuity. (Otto v.

Variable Annuity Life Ins. (7th Cir. 1986) 814 F.2d 1127, 1129.) The court held the employer's sole involvment of allowing the insurance company, along with other insurance companies, to advertise its program and, if chosen by the employee, to collect and remit premiums, constituted only minimal, ministerial activities which did not render the plan one established or maintained by the employer. (Id. at p.1135)

On the other hand, ERISA plans have been held to be established even when no employer contributions are made, but the circumstances show significant employer endorsement of the program through involvment. In Kanne v. Connecticut General Life Ins. Co., supra, 859 F.2d at pages 98-99, the court reviewed a plan administered by an employer group of which the litigating employee's employer

was a member. Pursuant to ERISA's requirements, the plan was established as a trust and the trust "purchased" a group health insurance from Connecticut General Life Insurance Company. The court noted the record was ambiguous as to whether the employer had contributed payments toward the employee's insurance coverage, or whether the employee's participation in the plan was voluntary or automatic. Further, the employer's function with respect to the plan was minor and ministerial, and no evidence suggested the plan was administered by a profit-making concern. Notwithstanding the lack of evidence as to the employer's involvment, the court held an ERISA plan was established by the employer group's involvment, which group was considered an employer for purposes of ERISA under section 1002, subdivision (5). The court observed the employer group intended to

create an ERISA plan, promoted it as an ERISA plan, and as administrator, endorsed it. Kanne concludes that because the employer group was more than a mere advertiser of group insurance, there need not be employer contributions or automatic employee coverage to bring the plan within ERISA.[4]

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4 Section 1002, subdivision (5) states: "The term 'employer' means any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benifit plan; and includes a group or association of employers acting for an employer in such capacity."

Apparently the court in Kanne concluded that the employer group involved therein (Associated Builders and Contractors) was a group acting for the employer. In contrast, other cases have indicated that an employer group which consists of heteregenous, unrelated employers is not an employer group recognized under ERISA. (See Credit Managers Ass'n. v. Kennesaw Life & Acc. Ins., supra, 809 F.2d at p. 625; Taggart Corp. v. Life & Health Benefits Admin. (5th Cir. 1980) 617 F.2d 1208, 1210; Donovan v. Dillingham, supra, 688 F.2d at p. 1375)

Similarly, in Shiffler v. Equitable Life Assur. Soc. of U.S. (E.D.Pa. 1986) 663 F.Supp. 155, 160-161, affirmed Shiffler v. Equitablle Life Assur. Soc. of U.S. (3d Cir. 1988) 838 F.2d 78, 82 footnote 4, the court found the existence of an ERISA plan, even though it was undisputed that criteria one, two, and four in the Department of Labor regulation were present, reasoning that a plan is excluded under ERISA only when all four criteria are met.

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The Kanne opinion does not elaborate precisely what functions were undertaken by the employer group as the administrator of the plan.

The court held the plan did not meet the third criteria, since the employer endorsed the plan by presenting it as belonging to its benefit package, collecting the insurance premiums and forwarding them to the insurer, permitting the employees to discuss the plan with their supervisors, and administratively processing claims.

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In contrast, no ERISA plan was found where the employer "endorsed" the policy sold by an insurance trust, but the employer had no control of the trust operation, contributed no funds on behalf of the employees, and the insurance brokers sold the policies directly to individual employees who paid the entire premiums. (Hamberlin v. VIP Ins. Trust[5] (D.Ariz. 1977) 434 F.Supp. 1196, 1198; see also Baucom v. Pilot Life Ins. Co. (M.D.N.C. 1987) 674 F.Supp. 1175, 1181 [although under the Department of Labor

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5 We note the district court in Arizona issuing the Hamberlin opinion is under the Ninth Circuit, the latter which issued the Kanne opinion finding establishement of an ERISA plan based on an employer group's "endorsement." The analysis in Kanne suggest an interpretation of the term "endorsement" as involving employer administration of a plan, not mere employer approval of a plan. Thus, Kanne does not appear to overrule Hamberline.

regulation mere endorsement may be enough to establish an ERISA plan, judicial precedent appears to require some degree of active involvment in the plan's founding or administration [6].)

Finally, we note that an employer's failure to meet ERISA's requirements for

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6 In Bausom, the court held that the defendants -- who were seeking removal of an action filed in state court to federal court -- had failed to carry their burden since no evidence had been presented as to how the plan was created or administered. The plaintiffs, who were members of a professional golf association and participants in a retirement plan, alleged they forwarded payments to an agent of Pilot Life Insurance Company. Other than an admission by the insurance agent that he was the administrator of the plan, there was no other evidence presented as to the administration of the plan; there was no evidence presented as to when the plan was established or the circumstances surrounding its establishment; and no copy of the plan itself was submitted. Thus, the court held assuming arguendo the golf association was an employee organization under ERISA, the defendants had failed to carry their burden to show the employee organization established or maintained the plan. (Bausom v. Pilot Life Ins. Co., supra, 674 F. Supp. at pp. 1176-1178, 1811.)

establishing a plan (i.e. written instrument, named fiduciaries, public reports, ets.) does not mean the employer can escape ERISA's coverage, if it is decided a program is under ERISA. (Scott v. Gulf Oil Corp. (9th Cir. 1985) 754 F.2d 1499, 1503-1504.)[7]

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7 It has been held that if an employer merely purchases insurance for his employees, with no intent to set up a plan and no knowledge the insurance program was organized under ERISA, he cannot be deemed to have established an ERISA plan. (Wayne Chemical, Inc. v. Columbus Agcy. Serv. Corp. (7th Cir. 1977) 567 F.2d 692, 699.) The concern in Wayne Chemical was that the insurance trust not be allowed to escape a state law limiting the circumstances under which a dependent's coverage may be terminated. (Id. at p. 700.) Arguably Wayne Chemical's nonpreemption holding could have been reached under ERISA's savings clause (section 1144, subd, (b)(2)(A)), which exempts from preemption state laws regulating insurance, unless they conflict with ERISA's provisions. (See Pilot Life Ins. Co. v. Dedeaux, supra, 107 S.Ct. 1549, discussed infra.) We question whether a test based on an employer's subjective intent is appropriate.

Rizzi relies on Taggart Corp. v. Life & Health Benefits Admin., supra, 617 F.2d 1208 for the proposition that no ERISA plan exists where the employer's sole involvment is to purchase insurance for its employees. In Taggart, a corporation purchased insurance for its sole employee, and the court held ERISA does not regulate "bare purchases of health insurance where, as here, the purchasing employer neither directly nor indirectly owns, controls, administers or assumes responsibility for the policy or its benefits." (Id. at p. 1211.) Taggart notes the employer did not participate in the day-to-day operation or administration of the program, and the corporation did no more than make payments to a purveyor of insurance, patently for tax reasons. (Id. at pp. 1210, 1211.)

In Donovan v. Dillingham, supra,

688 F.2d at page 1375, the Eleventh Circuit stated it agreed with Taggart if its holding is "interpreted to mean ERISA does not regulate purchases of health insurance when there is no welfare plan"; since the "purchase of insurance is only a method of implementing a plan, fund, or program and is evidence of the existence of a plan but is not itself a plan." On the other hand, Donovan disagrees with any interpretation of Taggart implying an ERISA plan can not be said to have been established if an employer only purchases a group health insurance policy. (Ibid.) The court in Donovan reasoned the purchase of insurance did not conclusively establish the existence of a plan, but it was evidence of a plan, and the purchase of a group policy covering a class of employess offered substantial evidence that a plan had been

established. (Id. at p. 1373.) Donovan notes the peculiar facts in Taggart -- i.e., the circumstances indicated the subscription simply involved the purchase of insurance by the employee for himself and his family. (Donovan v. Dilligham, supra, 688 F.2d at p. 1375, citing the district court opinion Taggart Corp. v. Efros (S.D.Tex. 1979) 475 F.Supp. 124.) We believe Donovan's caution is justified, and that under some circumstances an employer's purchase of insurance may be enough to create an ERISA plan, depending on an evaluation of all circumstances.[8]

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8 We note that although the Department of Labor regulation states an ERISA plan does not exist if, inter alia, no contributions are made by the employer, it does not necessarily follow that if an employer does make contributions, a plan automatically exists. In 29 Code of Federal Regulations section 2510.3-1(a)(4), the Department of Labor qualifies its regulation by stating, "[s]ome of the practices listed in this

Some light is shed on the issue of what types of programs were intended to be governed by ERISA in a United States Supreme Court case arising in a different factual context, Fort Halifax Packing Co.,Inc. v. Coyne (1987) 107 S.Ct. 2211. There, the court held a state law requiring an employer to provide a one-time severance payment to employees in the event of a plant closing was not preempted by ERISA, since the statute neither established, nor required an employer to maintain neither established, nor required an employer to maintain, an employer welfare benefit plan under ERISA. (Id. at p. 2215.) The court

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section as excluded from the definition of 'welfare plan' or mentioned as examples of general categories of excluded practices are inserted in response to questions received by the Department of Labor and, in the Department's judgment, do not represent borderline cases under the definition in section 3(1) [section 1002, subd. (1)] of the Act. Therefore, this section should

concluded an evaluation of both the express terms of ERISA and the legislative intent shows ERISA only preempts state laws relating to employee benefit plans, and not state laws merely relating to employee benefits. The court observed that the one-time severance pay statute did not require the employer to set up an administrative scheme -- i.e., it did not require the employer to assume responsibility to pay benefits on a regular basis, and thus, the employer faced no periodic demand on its assets that created a need for financial coordination and control; and it did not require the employer to create an ongoing adminstrative program to process claims and pay benefits. (Id. at p. 2218)

Fort Halifax concludes the statute

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not be read as implicity indicating the Department's views on the possible scope of section 3(1)." (Italics added.)

did not implicate the regulatory concerns of ERISA.[9] That is, ERISA was enacted to require disclosure and provide safeguards with respect to the establishment, operation, and administration of employee benefit plans; to prevent abuses of the special responsibilities borne by those dealing with the plans; and to prevent self-dealing, imprudent investing, and misappropriation of plan funds. Since the focus of the statute is on the administrative integrity of benefit plans, it presumes some type of administrative activity is taking place.

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9 Fort Halifax also concluded the statute did not conflict with the preemption purpose of ERISA. That is, the preemption purpose of ERISA was to establish a uniform set of regulations governing employee benefit plans, so that employers would not have to administer their plans differently in each state in which they have employees, and would thereby be encouraged to maintain and institute employee benefit plans. (Id. at pp.2216-2217.)

Thus, the court concluded that only "plans" involve administrative activity potentially subject to employer abuse; whereas the statute before it generated no such activity -- i.e., there was no occasion to determine whether a "plan" is "operated" in the interest of the beneficiaries, because nothing is "operated" and no financial transactions take place that would be listed in an annual report. (Id. at pp. 2219-2220.) The court in Fort Halifax recognized that an employer assuming responsibility to pay benefits on a regular basis faces periodic demands on its assets creating a need for financial coordination and control. Although a program which only involves the monthly payment of premiums from the employer's funds to an insurance company does not create the same level of administrative activity as other more expansive employee benefit plans (i.e.,

employer plans which have the responsibility of actually processing claims and paying out benefits when a claim is made), nevertheless, it does require the employer to set aside funds and makes the employees dependent on the employer's fiscal respnsibility.[10]

Applying by analogy the Fort Halifax analysis here, the line of

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10 Furthermore, we note that in the United States Supreme Court decision in Pilot Life Ins. co. v. Dedeaux, supra, 107 S.Ct. at p. 1551, the court's factual summary indicates it was apparently undisputed that an insurance program was an ERISA plan, through which program the employer collected and matched its employees's contributions to the plan and forwarded the funds to the insurer, and also supplied and forwarded claim forms. However, the insurer actually processed the claims. It does not seem that the mere ministerial duty of providing and transmitting claim forms should be a decisive factor in determining whether an ERISA plan exists; rather, the ERISA plan would appear to exist by virtue of the fact that the employer contributed funds to pay for the program regardless of whether the employees obtained the claim forms from the employer or directly from the insurer.

demarcartion between ERISA plans and non-ERISA plans depends on the level of involvment by the employer in the program so as to warrant federal regulation of the adminstrative integrity of the program. That is, when employers provide benefits to employees in a manner which involves the employer's administration of funds to be used for the employees, ERISA's concern with regulating the administrative integrity of the program arises. This in turn supports characterizing the program as an ERISA "plan."

Although factual differences and varying analytical approaches we have recited do not always coincide, the following general conclusions can be drawn from federal case precedent and the Department of Labor regulation. An employer may have (but has not necessarily) established an ERISA plan if

his main involvment is to contribute to the payment of the premiums. If the employer does not contribute to the premiums, but merely transmits the employee's premiums without endorsing the policy or profiting from the program, no ERISA plan has been established. On the other hand, whether the employer contributes premiums or not, if the employer has endorsed the program in the sense that he is significantly involved in it, an ERISA plan may have been established. The ultimate determination depends on an evaluation of all the circumstances, keeping in mind ERISA's purpose of regulating an employer's administration of benefit plans.

Evidence presented

Turning to the facts of this case, Blue Cross submitted a declaration of the former president and owner of New Way -- Troy Boal -- stating New Way published

various newspapers, one of which was mailed nationally to paid subscribers and included advertisements for products sold nationwide; in July 1975, New Way entered into a group service agreement with Blue Cross under which Blue Cross provided hospitalization and major medical benefits to eligible New Way employees; that an attached exhibit was a true and correct copy of a group service agreement; that Rizzi ceased active employment with New Way in approximately November 1976 after suffering a heart attack; and that New Way advised Blue Cross to terminate Rizzi's group health coverage effective February 1, 1977. Further, Blue Cross augmented the record on appeal with an excerpt from Rizzi's deposition in which he states he personally did not pay the insurance premiums, but they were paid by his employer. Rizzi does not dispute the

plain interpretation of his deposition testimony is that the employer, not himself, contributed the money for insurance premiums, indicating only that he has no present recollection of whether that meaning is factually correct.

The exhibit attached to Boal's declaration is entitled "Group Hospital and Professional Service Agreement" between New Way and Blue Cross.[11] The agreement recites, inter alia, the following.

-- A "subcriber" is an eligible employee under 65 years of age of the employer whose application for benefits has been accepted by Blue Cross and in whose name the identification card is issued by Blue Cross.

-- The subscription charges may be

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11 We find no merit in Rizzi's arguments that the agreement was not adequately authenticated.

increased upon 30 days written notice to the employer.

-- The employer shall pay, monthly in advance, all subscription charges of its employees.

-- If the employer fails to pay any installment of subscription charges, the agreement terminates without the necessity of notice to the employer or subscriber.

-- If the subscriber ceases to be employed by the employer, and after the payment of at least one installment of the subscription charges in the manner prescribed for the employer, his individual certificate shall terminate automatically without notice. But, the subscriber shall be entitled, upon notice to Blue Cross within 15 days of the date of termination of employment, to apply for a conversion privilege at the subscription charges then in effect.

-- If the agreement is terminated by the employer or the service, the individual certificates issued to the subscribers are terminated and no conversion privilege is available.

-- The service may not cancel any individual certificate issued to any subscriber remains in the eligible class of employees of the employer and his subscription charges are paid.

-- Any notice required of the service shall be deemed sufficient if mailed to the employer.

In opposition to Blue Cross's preemption claim, Rizzi submitted a declaration stating he understood he was not terminated but could have his job back when he recovered; he was never offered a plan entitled ERISA or covered by any regulation relating to ERISA; while he was employed in 1975, he enrolled in a group health insurance plan

he understood would be less expensive than an individual plan; he never saw his employer administer or manage the group insurance plan; he corresponded with Blue Cross and received mail from Blue Cross about the plan; and the group plan was not offered as part of an overall employee benefit package.

We are satisfied the clear interpretation of Rizzi's depositional statements is that the employer contributed to the insurance premiums. In light of that fact in context with the form of the Blue Cross plan showing other employer controls over operation of the program, Blue Cross carried its burden at the summary judgment hearing to establish the existence of an ERISA plan. There is no countervailing demonstration of a triable issue of material fact.

III.

FEDERAL PREEMPTION

The next issue is whether ERISA preempts actions brought under California Insurance Code section 790.03,[12] which, at the time this action was filed, created a private cause of action for unfair and deceptive acts or practices in the business of insurance. (See Moradi-Shalal v. Fireman's Fund Ins. Companies (1988) 46 Cal.3d 287, 305.)

Preemption of common law bad faith under Pilot Life case

Section 1144 contains (1) a preemption clause, which provides that it supersedes all state laws relating to any

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12 California Insurance Code section 790.03, subdivison (h) defines unfair practices as including such acts as misrepresenting policy provisions, failing to act promptly, not attempting in good faith to fairly settle when liability is reasonably clear, failing to promptly explain a denial, etc.

employee benefit plan[13]; (2) a savings clause, which exempts from preemption any state law which regulates insurance,[14] and (3) a deemer clause, which clarifies that a state law that purports to regulate insurance cannot deem an employee benefit plan to be an insurance company.[15]

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13 Section 1144, subdivision (a) [preemption clause] states: "Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975."

14 Section 1144, subdivision (b)(2)(A) [savings clause] states: "Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities."

15 Section 1144(b)(2)(B) [deemer clause] states: "Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section

(Pilot Life Ins. Co. v. Dedeaux, supra, 107 S.Ct. at p. 1552.)

In the Pilot Life case, the Supreme Court held that the common law clause of action for bad faith in an insurance contract was preempted by ERISA, stating that the state law did "relate to" an employee benefit plan so as to be covered under the preemption provision, but did not "regulate insurance" so as to be covered under the savings provision.[16] (Id. at pp. 1553-1554.) The court

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1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies."

16 If an ERISA plan exists, Rizzi does not contend his alleged common law causes of action are not preempted (i.e., duty of good faith, fraud, breach of duty).

reasoned that under a common sense view of the phrase "regulates insurance," a law must not just have an impact on the insurance industry, but must be specifically directed toward that industry, whereas common law bad faith was firmly planted in general principles of tort and contract law. (Id. at p. 1554.) Further, evaluating factors identified in the context of determining what constitutes "the business of insurance" under the McCarran-Ferguson Act,[17] the court reasoned that (1)

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17 The McCarran-Furguson Act, provides in part: "The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business." (15 U.S.C. section 1012, subd. (a).) The criteria delineated to define the "business of insurance" under the McCarran-Ferguson Act are (1) whether the practice has the effect of transferring or spreading a policyholder's risk; (2) whether the practice is an integral part of the policy relationship between the insurer and the insured; and (3) whether the practice is limited to entities within

although the common law bad faith did somewhat concern the policy relationship between the insurer and the insured, any such connection was tenuous at best since it did not define the terms of the relationship but merely allowed punitive damages under certain circumstances just as in any other contractual relationship; (2) common law bad faith law did not have the effect of spreading policyholder risk; and (3) it was not limited to the insurance industry since it was rooted in general priniciples available in all contract cases. (Id. at pp. 1553-1555.)

In a second component to its analysis, the court in Pilot Life stated that it must also interpret the savings clause by evaluating its role in ERISA as a whole. The court noted that since the

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the insurance industry. (Pilot Life Ins. Co. v. Dedeaux, supra 107 S.Ct. at pp. 1554-1555.)

state cause of action sought remedies for the improper processing of a claim for benefits under an ERISA-regulated plan, it must look to the legislative intent concerning the civil enforcement provisions provided by section 1132, subdivision (a). Examining the language and structure of the civil enforcement provisions as well as the legislative history, the court in Pilot Life was persuaded by the argument that Congress expressed an intent that the ERISA civil enforcement provisions be the exclusive vehicle for actions by beneficiaries asserting improper processing of a claim for benefits, and that various state causes of action for such claims would pose an obstacle to the purposes and objectives of Congress. (Id. at p. 1555.)

The court reasoned that the civil enforcement scheme (section 1132, subd.

(a) [18]) was one of the essential tools for accomplishing ERISA's stated purposes, along with the provision requiring every employee benefit plan to give notice to a

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18 Section 1132, subdivision (a) states in part: "A civil action may be brought -- (1) by a participant or beneficiary -- (A) for the relief provided for in subsection (c) of this section, or (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan; (2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title; (3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan; (4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 1025(c) of this title;..."

Subdivision (c) of section 1132 pertains to monetary penalties for refuslas to supply requested information; section 1109 pertains to breach of fiduciary duty; and section 1025, subdivision (c) refers to reporting of benefit rights.

beneficiary whose claim has been denied and an opportunity for review (section 1133), and a provision authorizing criminal penalties for violations of reporting and disclosure provisions (section 1131). Under the civil enforcement scheme, a plan beneficiary may bring a cause of action for breach of fiduciary duty and seek removal of the fiduciary; may sue to recover benefits due, to enforce rights, or to clarify rights to future benefits; may obtain relief in the form of accrued benefits, a declaratory judgment, or an injunction; and may be awarded attorney's fees. (Id. at pp. 1555-1556.)

The court noted that the detailed provisions of the civil enforcement scheme set forth a comprehensive scheme which represented a careful balancing of the need for prompt and fair claims settlement procedures against the public

interest in encouraging the formation of employee benefit plans, and the policy choices would be undermined if beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA. Further, the legislative history demonstrated that ERISA's preemptive force with respect to suits to enforce benefit rights or to recover benefits was modeled after the Labor-Management Relations Act (LMRA), allowing suits in federal or state courts governed under the laws of the United States, and Congress was well aware that the LMRA displaced all state actions for violations of contracts between an employer and a labor organization even when the state action purported to authorize a remedy unavailable under the federal provision. (Id. at p. 1557.) The court concluded the expectations expressed in the legislative history that

a federal common law of rights and obligations under ERISA-regulated plans would develop, and the comparison of ERISA's civil enforcement scheme to the LMRA, would make little sense if the remedies available to beneficiaries under ERISA could be supplemented or supplanted by varying state laws.

The court in Pilot Life summarized its holding by stating: "Considering the common-sense understanding of the saving clause, the McCarran-Ferguson Act factors defining the business of insurance, and, most importantly, the clear expression of congressional intent that ERISA's civil enforcement scheme be exclusive, we conclude that Dedeaux's state law suit asserting improper processing of a claim for benefits under an ERISA-regulated plan is not saved by [the savings clause], and therefore is pre-empted by [the preemption clause]." (Id. at p.

1558; italics added.)

Application of Pilot Life to California Insurance Code Section 790.03

In the recent Ninth Circuit case, Kanne v. Connecticut General Life Ins. Co., supra, 859 F.2d at page 100, the court assumed arguendo, without deciding, that unlike the common law bad faith cause of action, California Insurance Code section 790.03 is a state law regulating insurance under the savings clause.[20]

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19 Given the court's holding that the savings clause did not rescue the state common law claim from the effect of the preemption clause, the court stated it did not need to reach the argument that the insurance company should be protected from direct state regulation under the deemer clause. (Pilot Life Ins. Co. v. Dedeaux, supra, at p. 1558, fn. 4).

20 Some opinions of lower federal district courts in California have concluded Insurance Code section 790.03 is a state law regulating insurance within the meaning of the savings clause (Graves v. Blue Cross of California

Nevertheless, Kanne holds that under the second half of Pilot Life's analysis, the conclusion is inescapable that California Insurance Code section 790.03 is preempted by ERISA.[21] We agree.

(N.D.Cal. 1988) 699 F.Supp. 1405, 1409-1412; Lee v. Prudential Ins. Co. of America (N.D.Cal.1987) 673 F.Supp. 998, 1000-1001), whereas at least one has questioned that conclusion (see Roberson v. Equitable Life Assur. Soc. of U.S. (C.D.Cal. 1987) 661 F.Supp. 416, 422-424).

21 Some opinions of lower federal district courts in California have concluded Insurance Code section 790.03 is a state law regulating insurance within the meaning of the savings clause (Graves v. Blue Cross of California (N.D.Cal. 1988) 688 F.Supp. 1405, 1409-1412; Lee v. Prudential Ins. Co. of America (N.D.Cal. 1987) 673 F.Supp. 988, 1000-1001), whereas at least one has questioned that conclusion (see Roberson v. Equitable Life Assur. Soc. of U.S. (C.D.Cal. 1987) 661 F.Supp. 416, 422-424).

21 Prior to the Kanne opinion, several lower federal district courts in California had reached the same conclusion. (See Roberson v. Equitable Life Assur. Soc of U.S., supra, 661 F.Supp. at pp. 423-424; Lee v. Prudential Ins. Co. of America, supra, 673 F.Supp.

at pp. 1001-1002.)

On the other hand, notwithstanding the second analysis in Pilot Life, several courts (none of which opinions are of current precedential value) have concluded that ERISA does not preempt actions brought under Insurance Code section 790.03. These include Graves v. Blue Cross of California, supra, 688 F.Supp. at pages 1412-1413, which the Ninth Circuit's decision in Kanne has effectively overruled (as well as several other federal district court opinions cited by Rizzi which predate Pilot Life); and Goodrich v. General Telephone Co. (1987) 195 Cal.App.3d 675, 683, 691, for which review was granted to the California Supreme Court on December 23, 1987 (S002951). The court of appeal in Goodrich reasoned that it was illogical and in direct conflict with the unambigous language of the ERISA savings clause to construe Insurance Code section 790.03 as being both within and without the scope of the preemption clause. Further, the court in Goodrich interpreted Pilot Life as premised on the finding the common law bad faith cause of action was not a law regulating insurance, and therefore Pilot Life did not need to decide, and did not decide, whether there were any implied limits to the savings clause.

If not for the alternative analysis in Pilot Life, which concludes Congress has evinced an intent that all suits alleging improper claims processing be governed only be federal law under ERISA, we would be inclined to hold that Insurance Code section 790.03 is a state law directly aimed at the insurance industry and integrally related to the relationship between the insurer and the insured, and thus falls under the savings clause and is not preempted. However, we are bound by the statements in Pilot Life which emphasize that the most important basis for its preemption holding is that Congress intended ERISA's civil enforcement scheme pertaining to suits to enforce benefit rights to be exclusive and not to be supplemented by state law remedies. Regarding this component of Pilot Life's analysis, we see no basis to distinguish between a state common law,

as opposed to statutory, remedy for improper claims processing.

Accordingly, Rizzi is limited to an action under ERISA and not under California Insurance Code section 790.03.

DISPOSITION

The summary judgment is affirmed.

CERTIFIED FOR PUBLICATION

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WORK, J.

WE CONCUR:

_____
WIENER, Acting P.J.

_____
TODD, J.

STATUTORY PROVISIONS

Employee Retirement Income Security Act of 1974, as amended.

1. Sections 3(1), (7) and (8), 29 U.S.C. §§ 1002(1), (7) and (8). Definitions.

§ 1002. Definitions

For purposes of this subchapter:

(1) The terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise. (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in Section 186(c) of this title (other than pensions on retirement

or death, and insurance to provide such pensions).

* * * *

(7) The term "participant" means any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit.

(8) The term "beneficiary" means a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder.

2. Section 502(a), 29 U.S.C. § 1132 (A). Civil Enforcement.

§ 1132. Civil enforcement

(a) Persons empowered to bring a civil action.

A civil action may be brought--

(1) by a participant or

beneficiary--

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;

(3) by a participant beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (b) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provisions of this subchapter or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 1025(c) of this title;

(5) except as otherwise provided in subsection (b) of this section, by the Secretary (A) to enjoin any at or practice which violates any provision of this subchapter, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this subchapter; or

(6) by the Secretary to collect any civil penalty under subsection (i) of this section.

3. Section 505, 29 U.S.C. § 1135. Regulations.

§ 1135. Regulations.

Subject to subchapter II of this chapter and section 1029 of this title, the Secretary may prescribe such regulations as he finds necessary or appropriate to carry out the provisions of this subchapter. Among other things, such regulations may define accounting, technical and trade terms used in such provisions; may prescribe forms; and may provide for the keeping of books and records, and for the inspection of such books and records (subject to section 1134(a) and (b) of this title).

4. Section 514(a), 29 U.S.C. § 1144a. Effect on other laws.

§ 1144. Other laws

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

Regulations promulgated under Section 503 of ERISA, 29 U.S.C. 1133

1. 29 C.F.R. § 2510.03-1(j) (1987).

(j) Certain group or group-type insurance programs. For purposes of Title I of the Act and this chapter, the terms "employee welfare benefit plan" and "welfare plan" shall not include a group or group-type insurance program offered by an insurer to employees or

members of an employee organization, under which —

(1) No contributions are made by an employer or employee organization;

(2) Participation in the program is completely voluntary for employees or members;

(3) The sole functions of the employer or employee organization with respect to the program are, without endorsing the program, to permit the insurer to publicize the program to employees or members, to collect premiums through payroll deductions or dues checkoffs and to remit them to the insurer; and

(4) The employer or employee organization receives no consideration in the form of cash or otherwise in connection with the program, other than reasonable compensation, excluding any profit, for administrative services actually rendered in connection with payroll deductions or dues checkoffs.

2. 29 C.F.R. § 2560.503-1(g)(2) (1987).

(2) To the extent that benefits

under an employee benefit plan are provided or administered by an insurance company, insurance service, or other similar organization which is subject to regulation under the insurance laws of one or more States, the claims procedure pertaining to such benefits may provide for review of and decision upon denied claims by such company, service or organization. In such case, that company, service, or organization shall be the "appropriate named fiduciary" for purposes of this section. In all cases, the "appropriate named fiduciary" for purposes of this section may be the plan administrator or any other person designated by the plan, provided that such plan administrator or other person is either named in the plan instrument or is identified pursuant to a procedure set forth in the plan as the person who reviews and makes decisions on claim denials.

IN THE UNITED STATES SUPREME COURT

CERTIFICATE OF SERVICE

I hereby duly affirm that 3 each of the foregoing document was served to the following by depositing the same in the United States mail, postage prepaid, on _____, 1989, as follows:

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